SERFF Tracking Number:	*AMLC-126740032*	*State:*	*Arkansas*
Filing Company:	*Globe Life and Accident Insurance Company*	*State Tracking Number:*	*46340*
Company Tracking Number:	*ENROLLMENT FORM DG03*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Enrollment Form DG03*		
Project Name/Number:	*Enrollment Form DG03/Enrollment Form DG03*		

Filing at a Glance

Company: Globe Life and Accident Insurance Company

Product Name: Enrollment Form DG03	SERFF Tr Num: AMLC-126740032	State: Arkansas
TOI: MS08G Group Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 46340
Sub-TOI: MS08G.001 Plan A 2010	Co Tr Num: ENROLLMENT FORM DG03	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Author: Phylis Ballard	Disposition Date: 08/25/2010
	Date Submitted: 07/27/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Enrollment Form DG03	Status of Filing in Domicile: Pending
Project Number: Enrollment Form DG03	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Filed in Nebraska, our state of domicile, on this day.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 08/25/2010	Explanation for Other Group Market Type:
	State Status Changed: 08/25/2010
Deemer Date:	Created By: Phylis Ballard
Submitted By: Phylis Ballard	Corresponding Filing Tracking Number: Enrollment Form DG03

Filing Description:

Enrollment Form DG03 is being filed for use with our Group Medicare Supplement policies for individuals who are applying for coverage during their open enrollment period. These forms will be used on a direct response basis.

Company and Contact

SERFF Tracking Number:	*AMLC-126740032*	*State:*	*Arkansas*
Filing Company:	*Globe Life and Accident Insurance Company*	*State Tracking Number:*	*46340*
Company Tracking Number:	*ENROLLMENT FORM DG03*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Enrollment Form DG03*		
Project Name/Number:	*Enrollment Form DG03/Enrollment Form DG03*		

Filing Contact Information

Phylis Ballard, Compliance Analyst
3700 S. Stonebridge Drive
McKinney, TX 75070

pballard@torchmarkcorp.com
972-569-3748 [Phone]
972-569-3728 [FAX]

Filing Company Information

Globe Life and Accident Insurance Company
204 North Robinson Avenue
Oklahoma City, OK 73102
(405) 270-1400 ext. [Phone]

CoCode: 91472
Group Code: 290
Group Name: Liberty National
FEIN Number: 63-0782739

State of Domicile: Nebraska
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	1 Form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Globe Life and Accident Insurance Company	$50.00	07/27/2010	38320863

SERFF Tracking Number:	*AMLC-126740032*	*State:*	*Arkansas*
Filing Company:	*Globe Life and Accident Insurance Company*	*State Tracking Number:*	*46340*
Company Tracking Number:	*ENROLLMENT FORM DG03*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Enrollment Form DG03*		
Project Name/Number:	*Enrollment Form DG03/Enrollment Form DG03*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	08/25/2010	08/25/2010

SERFF Tracking Number:	*AMLC-126740032*	*State:*	*Arkansas*
Filing Company:	*Globe Life and Accident Insurance Company*	*State Tracking Number:*	*46340*
Company Tracking Number:	*ENROLLMENT FORM DG03*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Enrollment Form DG03*		
Project Name/Number:	*Enrollment Form DG03/Enrollment Form DG03*		

Disposition

Disposition Date: 08/25/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMLC-126740032*	*State:*	*Arkansas*
Filing Company:	*Globe Life and Accident Insurance Company*	*State Tracking Number:*	*46340*
Company Tracking Number:	*ENROLLMENT FORM DG03*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Enrollment Form DG03*		
Project Name/Number:	*Enrollment Form DG03/Enrollment Form DG03*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	DG03	Approved	Yes

SERFF Tracking Number:	*AMLC-126740032*	*State:*	*Arkansas*
Filing Company:	*Globe Life and Accident Insurance Company*	*State Tracking Number:*	*46340*
Company Tracking Number:	*ENROLLMENT FORM DG03*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Enrollment Form DG03*		
Project Name/Number:	*Enrollment Form DG03/Enrollment Form DG03*		

Form Schedule

Lead Form Number: Enrollment Form DG03

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 08/25/2010	DG03	Application/ Enrollment Form	DG03	Initial		52.250	DG03.pdf

ENROLLMENT FORM FOR INSURANCE • GLOBE LIFE AND ACCIDENT INSURANCE COMPANY
A LEGAL RESERVE STOCK COMPANY • ADMINISTRATIVE OFFICE: GLOBE LIFE CENTER • OKLAHOMA CITY, OK 73184

1. Please check name and address and complete other information requested.

Phone Number (_____)_____

E-mail address

Medicare I.D. # (Copy this number from your Medicare I.D. card.)

Date of Birth

_____
Month Day Year

☐ Male
☐ Female

2. Check the coverage you want.

Check one plan **only:**

	PLAN CODE
☐ Plan A	[J84]
☐ Plan B	[J85]
☐ Plan C	[J86]
☐ Plan F	[J87]

Payment Method Selected:

☐ Monthly ☐ Quarterly
☐ Semi-Annual ☐ Annual

Premium Submitted For Applicant:

$_____

3. Please answer the questions.

1. (a) Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

   (b) Did you enroll in Medicare Part B in the last six months? ☐ Yes ☐ No

   (c) If "YES", what is the effective date? _____

   (d) What is your Medicare Claim Number? _____

2. Are you covered for medical assistance through the State Medicaid program? ☐ Yes ☐ No
   NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer "NO" to this question. If you answer "YES".

   (a) Will Medicaid pay your premiums for this Medicare Supplement certificate? ☐ Yes ☐ No

   (b) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ☐ Yes ☐ No

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end date below. If you are still covered under this plan, leave "END Date" blank.

   START Date _____ END Date _____

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement certificate? ☐ Yes ☐ No

   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

   (d) Did you drop a Medicare Supplement certificate to enroll in the Medicare plan? ☐ Yes ☐ No

4. (a) Do you have another Medicare Supplement certificate in force? ☐ Yes ☐ No

   (b) If so, with what company, and what plan do you have? _____

   _____

   (c) If so, do you intend to replace your current Medicare Supplement coverage with this certificate? ☐ Yes ☐ No

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ☐ Yes ☐ No

   (a) If so, with what company and what kind of certificate? _____

   b) What are your dates of coverage under the other certificate? (If you are still covered under the other certificate, leave "END Date" blank.)

   START Date _____ END Date _____

PLEASE SIGN HERE

I have read and understand the statements on the reverse side regarding Medicare Supplement Coverage.

Signed at _____ This _____ day of _____ _____
(City) (State) (Year)

Signed _____
(Applicant's Name)

Please make this certificate effective on _____/_____/_____
Month Day Year

(Enrollment form continued)

4. Please read and sign your name below.

(1) You do not need more than one Medicare Supplement certificate.

(2) If you purchase this certificate, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement certificate.

(4) If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement certificate can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare Supplement certificate by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement certificate can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement certificate under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

▶ Please sign the signature line at the bottom of the reverse side.

I hereby apply to Globe Life And Accident Insurance Company for a certificate to be issued in reliance on my written answers to the above questions. The answers are, to the best of my knowledge and belief, true. I agree the certificate shall not be effective unless it has actually been issued.

I understand that loss due to injury or sickness for which medical advice was received or treatment was recommended or given by a physician within 3 months prior to the certificate effective date is not covered unless the loss is incurred more than 60 days after the certificate effective date, subject to the Time Limit on Certain Defenses provision and legal proceedings.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SERFF Tracking Number:	*AMLC-126740032*	*State:*	*Arkansas*
Filing Company:	*Globe Life and Accident Insurance Company*	*State Tracking Number:*	*46340*
Company Tracking Number:	*ENROLLMENT FORM DG03*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Enrollment Form DG03*		
Project Name/Number:	*Enrollment Form DG03/Enrollment Form DG03*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	08/25/2010

Comments:

Attachment:

DG03 Readability Cert.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	08/25/2010

Comments:

Filed under Form Schedule, because that is what is being filed.

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		

Bypass Reason: na

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		

Bypass Reason: na

Comments:

ARKANSAS

CERTIFICATION

This is to certify that the atached Policy Form **see below**

has achieved Flesch Reading Ease Score of * and complies with the requirements of Arkansas Stat. Ann. SS66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Michael J. Gaisbauer, Vice President

SUPPLEMENTAL FORMS	SCORE
Enrollment Form DG03	52.25

FORM S-1351(3) 5/82